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COMMUNITY SUPPORT PROJECT

Year 04

Program Development Plan

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MONTANA

COMMUNITY SUPPORT PROJECT

Year 04

Program Development Plan

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Part A

Program Development Plan

I. Introduction

Montana's Community Support Project started in January 1978. It was seen as a necessary extension and elaboration of the deinstitutionalization effort. Two and one-half years of focus on community alternatives to and prevention of hospitalization has brought some welcome changes and improvements in the care and treatment of the long-term mentally disabled. The program development strategy developed in the first year was based upon situations in existance in the 70's and needs revision for the 80's. Hence, this update for the period 3/1/81 - 6/30/82.

Sources of information consisted of ongoing C.S.P. and Division staff meetings, quarterly meetings of both the C.S.P. advisory committee and the direct service providers group, attendance at mental health center board meetings, institutional visits and Mental Health Association, consumer, minority and mainstream agency contacts. Developing and improving a series of statewide CSSs for severely mentally disabled adults has necessitated a widespread, diversified series of liaisons throughout Montana that has proved very valuable in obtaining a broad perspective of the needs of this clientele.

Program Plan Objectives

Planning for future activities in Montana is best seen through the following broad objectives:

1. To further implement, refine and update local demonstration models at South Central Montana Mental Health Center (Urban) and Eastern Montana Mental Health Center (Rural).

2. Continue the implementation of statewide program development strategy by adapting the demonstration models or elements of them in 3 core service agencies, Northcentral, Western and Southwest Montana Mental Health Centers.

3. To continue to focus on and further develop activities relative to the following areas: manpower, consumarism, minority affairs and public education.

4. To extend and amplify evaluation efforts.

2. Tasks

From these broad objectives, the following tasks logically explicate and amplify the content as well as build on and strengthen the 3rd year management plan.

Task #1

Continue to implement the 2 local CSS demonstration models, evaluating and changing as necessary.

Previous efforts to develop a rural and urban CSS model in Region III have had mixed results. The urban model offers an extremely effective and efficient example to the rest of Montana on how to develop and maintain a CSS in a mid size city, Billings. Attempts to create a rural model in Region III's satellite office of Lewistown have proved less successful. A recent survey of identified long-term mentally disabled clients in Region III shows that 82% of them reside in Yellowstone County, the county seat of Billings. Therefore the Region I mental health center has been selected to serve as the rural model for C.S.P. purposes. With a catchment area population of 97,000 and a geography of 49,000 square miles, Region I has 1.98

persons per square mile. No city in the area has over 10,000 people. A C.S.P. subcontract was negotiated on 7/1/79 for services to the long-term mentally disabled and the center has shown commendable zeal in developing a C.S.S. Lacking the extensive array of community services frequently in place in larger cities and with a limited budget, rural agencies face a different set of problems in serving the chronically mentally ill. Although Montana has chosen to subcontract with mental health centers for CSS development, the variations in centers is great and Region I in particular because of its rural nature is quite different from the original model demonstration center, Region III. With its lack of a major population base in the catchment area, the management plan calls for dispersion of services into three equal and separated area offices with satellite branches reporting in to each area. Three C.S.P. workers are in each area office and a fourth is located in an Indian reservation. Thus, this rural model starts with a widely dispersed staff and a reduced number of clients. It has three partial hospitalization projects, one in each area office and one group home. Emphasis in the coming year will be on converting the day care programming to psychosocial philosophy. This highlights using the "world of work program", screening for vocational training, development of vocational plans, establishing a temporary employment plan, utilizing the Clark Street Inn group home for a job training program, etc. With respect to residential care, focus will be on utilization of foster homes and increased services to landlords of the long-term mentally disabled. Extended services to families of the chronically mentally ill will be emphasized and continuation of outreach and identification on the Northern Cheyenne Indian Reservation. As the other mental health centers develop their own CSSs, the availability of a rural model in the state will help them in tailoring a system that includes rural concerns.

Region III will continue to develop and expand its urban model. Earlier attempts to develop a rural model have not proved beneficial and center feels at this point that the most cost efficient method is to bring its rural residents in to Billings for care and treatment. With its six group homes, volunteer casemanager system and two partial hospitalization programs this center has an impressive array of mental health services for the long-term mentally disabled. Its plans for the fourth year include; a half-way house with more extensive services than its present 24-hour supervised home; stabilization of Warm Springs State Hospital admissions by means of prioritization of slots, quarterly trips by staff to the state hospital and intensification of work with district judges; outreach to potentially underserved, at risk population and mainstream agencies; increased use of volunteer case managers, systematized follow-up of treatment plans, operation of a work placement service, ongoing employment for appropriate referrals; utilization of least restrictive environment through monthly reviews of existing group home placements. As an extension of the present management plan, efforts will be expended to develop a client advocacy group. In collaboration with the Mental Health Association a workshop for consumers is in the planning stage for the spring of '81. Continued efforts to collaborate with ethnic minority groups is seen as a major method of improving service delivery to Indians and Hispanics.

Task #2

Continue to Identify Issues with Implications for State Level Activities.

Two and one-half years of experience with C.S.S. development in the model demonstration agency has shown that gaps still exist and certain

needs are unmet in providing services to the long-term mentally disabled.

A major issue in Montana is rurality and distance. How to serve people close to their home, make programs accessible and available, have staff on hand 24-hours a day for crises, provide facilities that can be reached in a nominal time period, when a large percentage of the mentally disabled population live in small towns with sparse resources. The Region VIII and X combined regional learning community to be held in Yakima, Washington in October 1980 will explore and highlight the problems involved in developing a C.S.S. in a rural catchment area. To further accentuate this aspect and focus more emphasis, Montana plans to create a second model demonstration agency, one for rural C.S.S.s, located at Region I Mental Health Center.

Housing continues to remain a major obstacle to deinstitutionalization. The lack of residential alternatives at several points along a continuum of needs ranging from inpatient services to independent apartments remains problematic for the mentally disabled. Sufficient housing that will accomodate the wide range of needs displayed by this target population is a problem in all five catchment areas. Special housing needs such as the multiple handicapped or the assaultive type further accent the deficiency of least restrictive alternatives. In the coming legislative session, the Department of Institutions will submit a request for additional state funding for increased transitional housing for the chronically mentally ill. Two surveys conducted at Warm Springs State Hospital showed that 26% of the current population were discharge ready if adequate community housing was available. The State Mental Health Plan lists group homes as a high priority in the coming year.

Transportation is a problem. The mentally disabled frequently do not drive, have a car or a license and are dependent on public transportation. Buses are available only in the three biggest cities and even these are sporadic in their coverage. Federal urban mass transit programs offer help to the rural areas primarily but the distances are so great that time becomes a problem. Center owned vans purchased four years ago with Title XV funding are becoming obsolete and the competition for transportation among the various center components is a struggle. Participation by C.S.P. state coordinator on the state Transit Assistance Committee that allocates 16 (B) (2) funds will provide some leverage in meeting transportation needs.

Public Assistance programs (S.S.I., Medicaid and General Assistance) are frequently viewed by center personnel as a disincentive in many cases to a client's motivation to independence and competitive employment, since the achievement of these mean termination of a secure and consistant source of income (plus full Medicaid coverage) that is very difficult to reapply for, if the need arises. Current S.S.I. eligibility criteria also preclude many of the long-term mentally disabled. Medicaid funding with its emphasis on utilization of the medical model rules out many social need programs and limits the income centers receive for work with this population. The necessity of providing professional staffs up to and including physicians, disallowing funding for many psychosocial programs as they currently exist. To date efforts to obtain Title XX funding have proved futile but continued efforts will be expended in this area.

Myths and misconceptions about the chronically mentally ill population are still very prevalent today, and a major push toward public re-

lations and education is seen as vital for the continued success of community-based programs, and for the target population to be accepted as productive members of society. The Region III Mental Health Center mentioned difficulty in obtaining sites for residences, finding employment opportunities for clients and involving community members in programs (i.e., as volunteers or on advisory boards), and urged that state and federal agencies increase positive use of the media to develop programming aimed at community awareness and understanding of the clientele involved. There is interest in negotiating with locally-based television stations to film currently existing activities taking place in the community. The nationally produced Public Broadcasting System film "Back Wards to Back Streets" which features Montana's model demonstration agency, was shown statewide in August with a panel discussion following.

Special attention is being paid in the core service agencies to developing relations with potential employers and generic community-based agencies that could be viable resources for the clients.

Task #3

Continue to develop and implement methods for state-level interagency collaboration and policy modifications.

A major method of keeping abreast of activities of other state agencies is through the quarterly meetings of the C.S.P. Advisory Committee which is made up of representatives of mainstream agencies and minority and citizen participants. This in turn leads to reciprocal requests for C.S.P. staff to serve on other agency committees and facilitates and promotes interagency dialogue on a variety of issues. For example, participation of

Rehabilitative Services Division on C.S.P. advisory committee has prompted the signing of a joint Mental Health - Voc Rehab working agreement on a state level. It is hoped this document will serve as a model for emulation on the local level for the core service agencies. As an outgrowth of this cooperative endeavor, beginning meetings have established a need for a statewide Vocational Workshop for these agencies dealing with the long-term mentally disabled. Plans for the fourth year include developing similar working agreements with the Department of Social and Rehabilitation Services, the Department of Health and Environmental Sciences, the Department of Labor and Industry, the Office of Public Instruction and the Department of Community Affairs and extension of local efforts at interagency collaboration.

Mental Health Association collaboration regarding a consumer workshop in Billings was effected recently and the workshop is planned for April 1981. A consumer consultant in this year's contract has the potential for further expanding C.S.P. contact with the Mental Health Association. Development of family and patient consumer groups in the coming year will be greatly facilitated with this organization's participation.

C.S.P. membership on the Health Department's Long Term Care Committee in the past 9 months has led to an extensive needs survey and resource study in Montana for this group. The interests of the long-term mentally disabled will be actively pursued in continued planning and implementation meetings.

Successful contractual relationships this year resulted in the opening up of an adolescent treatment unit at Region II Mental Health Center.

Funds from the Department of Institutions, the Office of the Superintendent of Public Instruction and the Department of Social and Rehabilitation Services were utilized to provide an alternative to the children's unit at Warm Springs State Hospital and out of state children's treatment center referrals. It is hoped that the upcoming revision of C.S.P. guidelines will include the seriously emotionally disturbed youth and thus bring this population at risk under the purview of Montana's C.S.P. Unit.

Task #4

Continue to implement the state program development strategy

Region II Mental Health Center became a core service agency on 3/1/80. Northcentral (Region II) Mental Health Center has a catchment population of 147,000 and covers 24,000 square miles. Bordered on the North by Canada, the topography is mainly rolling plains with agriculture and ranching its most important sources of income. Great Falls (population 60,000) is its major city and is located in the South Central part of the catchment area. Three reservations are located within Region II. The center budget of $1,900,000 is comparable to Region III and it also has a strong aftercare program with 4 day treatment units and an inpatient psychiatric unit at the local general hospital in Great Falls. In its first few months of CSS development, this center has focused on: opening a Thrift Shop, offering outreach to potentially unserved groups such as rural residents, ethnic minorities and nursing home residents; workshop planning for partial hospitalization workers; increasing slots for its temporary employment program; maintenance of four volunteer pre-employment work units; development of three pre-vocational work skills classes. In the coming year this center wants to develop state hospital - center - reservation linkages, institute

closer working relationships with mainstream agencies to facilitate better utilization of existing community resources (S.S.I. eligibility is a problem) (Cascade County jail needs mental health consultation) establish an inventory of landlords who house individuals requiring long-term care, to investigate and possibly develop a specialized program for dealing with unmotivated chronic patients currently living at Hospitality House; to provide structured living skills in formalized classes in the areas of: communication, nutrition, budgeting, meal planning and household maintenance, establish a 24-hour supervised group home, establishment of client grievance procedures and educating clients regarding their rights.

Region V Mental Health Center is to be subcontracted with for CSS services on 9/1/80. Western (Region V) Community Mental Health Center has a catchment population of 170,000 and covers 20,000 square miles. Bordered on the North by Canada and on the West by Idaho, its topography is primarily mountains with lumbering and tourism its major occupations. Missoula (population 30,000) is the major city and is located in the Southcentral part of the catchment area. The Flathead Indian Reservation and the University of Montana are located in this area. The center budget is $1,200,000 and the center has 47 F.T.E.s. To facilitate the care and treatment of the mentally disabled, five mental health workers have been hired to work out of the satellite offices and a group home has been established in Kalispell. The center partially funds a unique privately owned group home in Stevensville. This facility utilizes over 100 volunteers in a variety of capacities which insures widespread knowledge and acceptance of this agency in this small town (population is 4,000). Three partial hospitalization programs exist in Missoula, Kalispell and Libby. The local general hospital has an inpatient psychiatric unit. With the

development of a CSS, the center plans for a strong vocational component that will include a thrift shop, cleaning services work crew and an additional, separate partial hospitalization program for those clients that opt for and can benefit from a work learning experience. Impressed by the Volunteer Case Management System established at the model demonstration agency, this center plans for hiring a volunteer coordinator for extension and elaboration of a volunteer program for the long-term mentally disabled. A new cooperative group home will be established with 4 beds at first and 4 more at a later date. Plans for an active agency coordination process through interagency case problem solving sessions are under way.

Region IV Mental Health Center is to be subcontracted with for CSS services on March 1, 1980. Southwestern (Region IV) Community Mental Health Center has a catchment area population of 178,000 and covers 29,000 square miles. Warm Springs State Hospital is located in this catchment area. Bordered on the South and West by Wyoming and Idaho, its topography is primarily mountainous with lumbering, agriculture, mining and tourism its major sources of revenue. Helena (25,000) and Butte (25,000) are the two major population centers and are located in the central and northern sections of the catchment area. The center budget is $1,300,000 with 50 F.T.E.s. Services for the chronically mentally ill have developed in the two major cities with a group home, partial hospitalization, sheltered workshop, social club and parent advocacy group in Helena and inpatient care at a psychiatric unit, partial hospitalization patterned on the psychosocial model and cluster groups patterned after the Fairweather model in Butte. In the coming year this center plans to expand its vocational efforts, develop a new group home and extend its advocacy component. A consumer workshop is planned for November 1980 in Butte and more cluster

groups in collaboration with Warm Springs State Hospital are planned for March 1981. In Helena there is continual efforts to develop an inpatient psychiatric unit at St. Peter's Hospital and independent living alternatives are needed for the long-term mentally disabled.

With all five community mental health centers subcontracting with the state C.S.P. for services to the long-term mentally disabled by March 1981, a mechanism for monitoring progress has had to be developed. A component assessment instrument (see Appendix A) has been devised and run at the model demonstration agency and Region II. Based on the ten essential elements of a C.S.S., it provides a tool for assessing strengths and weaknesses of the system. The trial runs have shown it to be easy to administer and it is planned to utilize it yearly at the time of the annual Mental Health and Residential Services Division's site visit to each center.

C.S.P. collaboration with the Manpower Unit has proceeded well. Up to this point there has been a strong emphasis on joint efforts in the area of workshops for the centers and institutions. In the coming year ongoing consolidation of these beginning training efforts will be focusing on capacity building. The Manpower data collection system will be in place by that time and will allow for such things as analyzing and comparing staffing patterns across agencies and examining program effectiveness as a function of staffing patterns and staff mix. A study of paraprofessionals will allow for more appropriate use of these vital staff members in the case of the long-term mentally disabled. A planning committee from C.S.P. and Manpower Development Units is meeting on a worker exchange program between the five community mental health centers, Warm Springs State Hospital and the Center for the Aged.

Funding for expanded program development for the long-term mentally disbled is an ongoing process. The Mental Health and Residential Services Division plans to introduce a bill in the coming legislature (January - March 1981) to permit and fund an increase in group home development. A study is being conducted now to determine more accurately the amount of money being expended by mental health centers in the care and treatment of the chronically mentally ill. This will be useful in the yearly allocation process of state funding for community mental health services. Programs for the long-term mentally disabled have a high priority with the Mental Health and Residential Services Division and by next year this allocation process will be based on contracts for services.

Technical assistance to core service agencies has been a focus from the beginning of the Montana C.S.P. and establishment of a state C.S.P. liaison worker at Warm Springs State Hospital has greatly facilitated the necessary interaction between hospital and community. Recently a formal C.S.P. technical assistance mechanism was adopted, patterned after the Region VIII T.A. operating under P.L. 94-63, Section 206(e). As all five community mental health centers step up their C.S.S. development, increases in requests for technical assistance have been felt in the state office. A review committee has been formed, a request format developed and a specific amount of money budgeted for this purpose. Further experience between now and March, 1981 with this mechanism, will help the state office to systematize and prioritize what were heretofore random requests. It is expected that technical assistance will play a larger part in the budget in the coming year.

One of the surprising findings of the January, 1980 client identification study done by the state C.S.P. office was that a large number of the long-term mentally disabled known to the centers were never seen at Warm Springs State Hospital. This has led to a plan to explore with the nearby Veteran's Administration Center in Sheridan, Wyoming, the amount and extent of Montana patients seen and discharged from this federal installation and to systematize the referral methods to prevent clients being lost in the process.

Task #5

Continue Implementation of CSS - Manpower Collaborative Actions Plan.

Present Management Plan calls for joint collaboration on developing a chronic mental illness component for the training of Native American paraprofessionals (M.U.I.A. grant), on forming a subcommittee of the MHA on consumer advocacy on a statewide partial hospitalization conference, on developing an "externship" program for clinical psychology students in rural Montana, and on replicating Region III's training program for volunteer case managers throughout the state. These activities lead logically to the C.S.P. developing a shared T.A. state process with Manpower on staff development for those working with the long-term mentally disabled. An exchange of workers program between Warm Springs State Hospital and the five centers is planned for year 04 as well as a Warm Springs State Hospital hosted Voc Rehab workshop for mental health and Voc Rehab staffers. Ongoing in service training at Lewistown Center for the Aged will be continued in year 04. C.S.P. assisted Manpower in devising and promulgating a training needs assessment and manpower instrument. When results of these tests are tabulated, more extensive planning can be implemented.

Task #6

Continue to Identify and Address C.S.P. Minority Concerns

In its third year, the C.S.P. focus on minority issues was in gathering data on Hispanics, Indochinese and Native Americans, identifying special needs and facilitating minority participation in state/regional C.S.S. activities. Progress in obtaining these objectives has been slow but progressive. Plans for the fourth year, based on progress so far, will be directed at engaging in mutually productive projects, more extensive planning and collaborative methods and aligning minority service providers with the state C.S.S. Ongoing study of demographic date, incidence and prevalence material and identification processes will be aided by the release of 1980 census reports that can shed some light on a notoriously dimly lit area. Montana will collaborate with the C.S.P. Minority T.A. contract being developed.

Task #7

Continue CSS Evaluations

Year 03 has seen the initiation of two major evaluation activities by the state C.S.P. First, a "Component Assessment Instrument" (CAI) was developed for the purpose of monitoring CSS growth and development in the various mental health regions. A list of approximately 50 numerical indicators were compiled, using both federal guidelines and locally relevant information (see Appendix, page 27, for a list of the indicators and the sources from which they will be derived).

Each indicator has been designed so as to capture one aspect of one of the ten essential CSS components. Further, each indicator has an optimum level clearly specified, so that percentage of attainment

can be measured. Information for the indicators comes from four major sources: 1) records of the state psychiatric hospital, 2) a sample of CSP client records, 3) a brief questionnaire given to case managers, and 4) interviews with CSP administrative staff.

So far, the instrument has been administered in Regions III (May, 1980) and II (July, 1980). The CAI was found to be worthwhile device, but a few refinements were added to it based upon experiences in these regions. All regions will have been assessed by the end of 1980, and will be reassessed at regular intervals to monitor CSS development. This system of assessments will serve to police contract requirements. Also, in the case of Region IV, due to enter CSP during March, 1981, the results of the assessment will help in negotiating the contract.

Region V, scheduled to enter CSP on September 1, 1980, offers an opportunity to conduct a pre-post comparison with the CAI. This region will be assessed during the last week of August, 1980, and again six months later, to assess the impact of the entrance into CSP upon CSS growth.

Reports of the assessments will be forwarded to the federal CSP office as they are prepared.

The second major evaluation effort launched during year 03 is a longitudinal follow-along study of CSP clients. An instrument, adapted from one developed by the Iowa Mental Health Authority, has been developed for assessing the clients' social adjustment, living skills, stress-resistance and overall adjustment. In addition, a checklist capturing detailed information about community-based services received will also be completed. The instrument (a draft of which is in the Appendix, page 33)

will be administered to a random sample of CSP clients at 3 month intervals, with the first assessment to be completed upon entrance to the CSP programs.

A system will be set up, whereby the program evaluator will be notified by the CMHC staff when a new CSP client arrives at the center. If randomly chosen to be monitored, a schedule of quarterly assessments will be set up by the evaluator, who will ensure that the data is collected at the required times. The ratings will be made by the case manager most familiar with the clients case.

The data from this assessment will serve a number of purposes. Firstly, it will give CSP management and funding decision-makers a much clearer idea of what their dollars are buying in terms of client improvement. Second, the data will help to pinpoint problem areas, that is, which kinds of clients are not showing adequate progress. Third, the relationship of CSS services delivered to outcomes obtained (not available from the in-place CMHC management information systems) will be specifiable.

The most serious impediment to success of this outcome system is the sheer volume of reporting and record-keeping already required of the case managers. To compensate the CMHCs for the extra time demanded of their staff, some additional funds will be included in the CSP sub-contracts. Approximately twenty clients will be assessed per center per year. Assessments at four times per year will mean a total of 400 assessments. Four thousand dollars will be allocated to the sub-contracts so that the centers are reimbursed at a rate of $10.00 per assessment. It is felt that the accuracy, completeness and quality of the data obtained will be substantially increased by this procedure, and that it

will cause the centers to cooperate in spirit instead of just a token fashion.

A final evaluation task which the CSP has set for itself during year 04 is to undertake a complete cost analysis of CSP clients in all five regions. This data will be used to document the State of Montana's extensive financial expenditures upon the CSP client, and will be useful in planning.

Whenever necessary, special studies will be conducted by the evaluator to address any questions, answerable with data, that may arise during year 04.

Task #8

Participate in CSP Learning Community Conference

Extensive participation by Montana's CSP in the planning for a regional learning community scheduled for Yakima, Washington in October, 1980 has pointed up the value of state and local participation for optimal attendance. A national learning community held in Washington D.C. in the spring of 1981 can call on extensive state and regional help to provide maximum benefits. In spite of increasing transportation costs, Montana will be attending the regional meeting with a full delegation as it is seen as an effective method of gaining new insights and increased statewide interest. Attendance by minority, consumer and mainstream agencies will further aid CSS involvement.

Task #9

Provide a Management Plan progress report and Final report to NIMH.

A management plan based upon the technical proposal for the fourth year will be developed by April 1, 1981.

A progress report emphasizing progress in achieving the management plan objectives will be developed by October 31, 1981.

A Final report serving as an annual report that details accomplishments of the fourth year will be due in to N.I.M.H. on June 30, 1982.

3. Rationale For Proposed Fourth Year Tasks and Activities

The CSP in Montana started in January 1978 with three state level FTEs in Helena, and three local demonstration FTEs at the South Central Montana Mental Health Center. In this first year planning and assessment functions were the major efforts of the state staff while the local office focused on developing a model CSS in Billings. In February 1979, the program development strategy for Montana was completed and in July, Region I, Eastern Montana Mental Health Center became a core service agency with three workers assigned to the three area offices. Increased activities in Manpower and Minorities, continuing efforts to refine the local demonstration models and technical assistance to Region II Mental Health Center as it became a core service agency occupied staff in the first half of the third year. Evaluation played an important part in these years as well as maintaining active liaison between Warm Springs State Hospital and the centers. On both the state and local levels major importance has been assigned to developing collaborative working relationships with mainstream agencies. The CSP advisory committee has continued

to meet quarterly to help solve problems and plan new approaches. The direct service providers group also meets quarterly with a goal of advising the CSP and improving collaboration among mental health service providers statewide.

On the local level, the South Central Montana Mental Health Center has opened a new cooperative group home to replace its independent living facility, has expanded its work training program to include food handling as well as janitorial experience, and is making a major thrust in developing volunteer case managers. Older adult services programming expanded this year in this center and this increased capability fits in nicely with CSP service to the elderly. The Eastern Montana Mental Health Center has staff in place, has identified the chronically mentally ill population and is serving the two reservations within its catchment area by means of subcontracts. It will intensify its rehabilitative efforts and work at collaboration with mainstream agencies in the fourth year. Due to the large geographic area, this core service agency will be modeling a rural CSP service. One mental health center, Region II, became a core service agency and has a good start on CSS development. Northcentral has opened a Thrift Shop in its first six months. Western Montana Mental Health Center is to subcontract for CSP on September 1, 1980 and is taking a strong interest in volunteer services for the chronically mentally ill as well as strengthening its rehabilitation component.

On the state level continued program development has played a key role in year 03. With four core service agencies functioning in the third year, efforts to insure evaluative mechanisms, meet manpower training needs and provide technical assistance has been a major focus. Ongoing work to include minority and consumer CSP concerns will be needed in the

fourth year. Monitoring of five core service agencies, developing alternative sources of funding and maintaining liaison between centers and state hospital will represent an expanding and ever broadening workload. The experience and know how obtained from the first three years will allow assimilation of this with existing staffing.

It is expected that CSS development in Montana will be of value to federal CSP office in its attempts to develop a CSS nationwide. All states have rural concerns and development of a statewide CSS in a rural state will be of interest across the nation. The utilization on a state level by CSP of a full time professionally trained evaluator and hospital-community liaison worker also offers a dimension of experience that should prove helpful.

B. Funding Strategy

The funding strategy proposed in the 1979 Program Development Strategy paper envisioned a declining subcontract amount to each center but this was changed in the January 1980 Business Proposal to reflect our learned experience of the value of continuity and sustained maximal effort. Thus, the present strategy envisions starting a core service agency with $50,000 for the first year, reducing the subcontract to $40,000 the second and then maintaining this level through years 03 and 04. This has the benefit of offering in the first year an opportunity to use start-up funds for particular felt needs and ongoing funding for sustaining these programs over a period of years. This theory also is predicated on the belief that the model demonstration concept can prove itself viable and worth continuing on a maintenance level by the state after the four year project terminates. At this point in time our evaluation data and observations show extremely good results for this two and one-half year old effort. The Mental Health and Residential Services Division

staff and administrator are pleased with CSP progress and are in the midst of planning for state assumption of present functions and expanding horizons for a fifth, sixth or seventh year new systems approach.

The financial plan presented on page 24-26 is based upon cost for tasks. Neither the Center's M.I.S.s nor the State's Budgeting and Accounting System are calibrated adequately with appropriate cost centers to capture information to point up all the tasks. Thus, Tasks 2, 3, 5, 6, 7 and 9 are put into one category with estimated C.S.P. expenditures. Tasks 1 and 2 are computed on the expenditure findings (see Appendix C) of the model demonstration agency for the period 7/1/79 - 3/31/80. This same percentage (42%) was then utilized for all Centers.

The major increase in this financial proposal lies in bringing Region IV into the program development strategy at $50,000 for its first year as a core service agency (See Task 4). This catchment area with the largest population and (due to its proximity to Warm Springs State Hospital) the biggest number of identified long-term mentally disabled poses the most acute problems in our program development strategy. The center budget is modest with a relatively small number of FTEs, yet with its history of collaboration with the state hospital it can have meaningful results as a core service agency. In some ways Montana's CSP has saved the hardest for the last on the theory that experiences gained in the first three years will be most useful in providing meaningful services to this population in Region IV.

Small increases are also reflected in tasks 5 (5,000) and 7 (8,000) wherein additional data collection and formal adaption of a state technical assistance program are needed.

Due to previous difficulty in synthesizing the CSP year (3/1/80 - 2/28/81) with the state fiscal year (7/1/80 - 6/30/81) and the resulting problems incurred, this budget envisions a sixteen month period. It is

further subdivided into a twelve month, four month and sixteen month period. The additional four months will be needed also for Region IV to develop its core service program as it took the model demonstration agencies, Region III and Region I that long to perfect their models.

The total federal CSP budget request is $511,171 for a sixteen month period.

MONTANA COMMUNITY SUPPORT PROJECT
Budget - 3/1/81 through 6/30/82

August 26, 1980

I. (3/1/81 - 2/28/82) -- (12 months)

Unit	Federal CSP $	Unit	State CSS $	Unit	Local CSS $	Total CSS $
Task 1 - Model Demonstration						
Region I	$37,000	Reg. I	$306,250	Reg. I	$161,242	$ 504,492
Region III	37,000	Reg. III	353,744	Reg. III	415,350	806,094
State Office	20,000					20,000
Total	$94,000	Total	$659,994	Total	576,592	$1,330,586
Task 2,3,5,6,7 & 9 - Other						
State Office	$103,129		--		--	$ 103,129
Task 4 - Program Development						
Region II	$37,000	Reg. II	$245,011	Reg. II	$493,372	$ 775,383
Region IV	47,000	Reg. IV	294,886	Reg. IV	239,746	581,632
Region V	42,000	Reg. V	269,776	Reg. V	228,775	540,551
State Office	25,000					25,000
Total	$151,000		$809,673		$961,893	$1,922,566
Task 8 - Learning Community						
Region I	$ 3,000		--		--	$ 3,000
Region II	3,000		--		--	3,000
Region III	3,000		--		--	3,000
Region IV	3,000		--		--	3,000
Region V	3,000		--		--	3,000
State Office	6,000		--		--	$ 6,000
Total	$21,000					$ 21,000
TOTALS	$369,129		$1,469,667		$1,538,485	$3,337,281

II. (3/1/82 - 6/30/82) (4 months)

Unit	Federal CSP $	Unit	State CSS $	Unit	Local CSS $	Total CSS $
Task 1						
Reg. I	$12,333	Reg. I	$ 102,083	Reg. I	$ 55,747	$ 170,163
Reg. III	12,333	Reg. III	117,915	Reg. III	138,450	268,698
State Office	6,667		--		--	6,667
Total	$31,333		$ 219,998		$ 194,197	$ 445,528
Tasks 2,3,5,6,7 & 9						
State Office	$ 44,376		--		--	$ 44,376
Task 4						
Reg. II	$ 12,333	Reg. II	$ 81,670	Reg. II	$ 164,457	$ 258,460
Reg. IV	12,333	Reg. IV	98,295	Reg. IV	79,915	190,543
Reg. V	12,333	Reg. V	89,925	Reg. V	76,258	178,516
State Office	8,333		--		--	8,333
Total	$ 45,332		$ 269,890		$ 320,630	$ 635,852
Task 8						
Reg. I	$ 3,000		--		--	$ 3,000
Reg. II	3,000		--		--	3,000
Reg. III	3,000		--		--	3,000
Reg. IV	3,000		--		--	3,000
Reg. V	3,000		--		--	3,000
State Office	6,000		--		--	6,000
Total	$ 21,000					$ 21,000
TOTALS	$142,041		$ 489,888		$ 514,827	$1,146,756

III. (3/1/81 - 6/30/82) -- (16 months)

Unit	Federal CSP $	Unit	State CSS $	Unit	Local CSS $	Total CSS $
Task 1						
Reg. I	$ 49,333	Reg. I	$ 408,333	Reg. I	$ 216,989	$ 674,655
Reg. III	49,333	Reg. III	471,659	Reg. III	553,800	1,074,792
State Office	26,667		--		--	26,667
Total	$125,333		$ 879,992		$ 770,789	$1,776,114
Tasks 2,3,5,6,7&9						
State Office	$147,505		--		--	$ 147,505
Task 4						
Reg. II	$ 49,333	Reg. II	$ 326,681	Reg. II	$ 657,829	$1,033,843
Reg. IV	59,333	Reg. IV	393,181	Reg. IV	319,661	772,175
Reg. V	54,333	Reg. V	359,701	Reg. V	305,033	719,067
State Office	33,333					33,333
Total	$196,332		$1,079,563		$1,282,523	$2,558,418
Task 8						
Reg. I	$ 6,000		$ --		$ --	$ 6,000
Reg. II	6,000		--		--	6,000
Reg. III	6,000		--		--	6,000
Reg. IV	6,000		--		--	6,000
Reg. V	6,000		--		--	6,000
State Office	12,000					12,000
Total	$ 42,000					$ 42,000
TOTALS	$511,170		$1,959,555		$2,053,312	$4,524,037

Appendix A

COMPONENT ASSESSMENT INSTRUMENT

I. Identification and Outreach

	Aspect	Indicator	Source
A.	Discharge notification	1-(Number of WSSH discharges to region without prior notice ÷ total discharges), last quarter	CSP staff, WS database
B.	WSSH prescreening	Number of WSSH admissions screened prior to admission ÷ total WSSH admissions, last quarter	WSSH database
C.	CMHC followup of WSSH discharges	Number discharged from WSSH who are receiving CMHC services ÷ total number discharged to region, last quarter	WSSH & CMHC databases
D.	Inappropriate admissions	Number of appropriate admissions ÷ total WSSH admissions, last quarter	WSSH database
E.	Relations with nursing homes	For each nursing home: regular, on-going relationship with CMHC staff? Y or N	CSP staff
F.	Community outreach	For previous year: 1)one or more attempts to locate new groups of chronically mentally ill? Y or N 2) one or more attempts to reach each significant minority group? Y or N	CSP staff
G.	CSP screening	Are new aftercare clients routinely screened for CSP eligibility? Y or N	CSP staff
H.	Discharge-ready patients	Number of discharge-ready patients at WSSH ÷ total patients (for a given region)	Social workers at WSSH

II. Crisis Assistance

	Aspect	Indicator	Source
A.	24-hour telephone availability	For each satellite: hours per day telephone assistance is available (0 to 24)	CSP staff
	Crisis visit capability	For each satellite: hours per day staff are available to visit crisis site (0 to 24)	CSP staff

Crisis Assistance (continued)

	Aspect	Indicator	Source
C.	Short-term crisis beds	Number of crisis beds available ÷ number needed	CSP staff, case managers
D.	Crisis phone number publicity	For each satellite: is crisis phone number publicized in 1) yellow pages? Y or N 2) newspaper? Y or N - No. of times per year 3) radio? Y or N - No. of times per year 4) Other_____? Y or N	CSP staff
E.	Training of community care-givers	For past year: one or more efforts by CMHC staff to train community care-givers in crisis management? Y or N	CSP staff
F.	Crisis log book	Crisis log book maintained? Y or N	CSP staff

III. Benefits Assistance

	Aspect	Indicator	Source
A.	Written agreements with benefit agencies	Number of written agreements ÷ by number of benefit agencies identified	CSP staff
B.	Eligibility screening	For each type of benefit: number of clients screened for eligibility ÷ by number who may be eligible	Case managers
C.	Application success	Number of successful applications ÷ by total number of applications	Case managers

IV. Psychosocial Rehabilitation

	Aspect	Indicator	Source
A.	Work evaluations	Number of clients work evaluated ÷ by number unemployed but employable	Case managers
B.	Daytreatment placements	Number of clients attending day-treatment two or more times per week ÷ number needing daytreatment (excluding supportive clients)	Case managers

Psychosocial Rehabilitation (continued)

	Aspect	Indicator	Source
C.	Employment training	Number receiving employment training ÷ number needing it (excluding supportive clients)	Case managers
D.	Employer outreach	Number of employers approached on behalf of ready-to-work clients ÷ number of ready-to-work clients	Case managers
E.	Competitive employment placements	Number in competitive employment settings ÷ number needing competitive employment	Case managers
F.	Residential capacity	Number of residential beds ÷ number needed	Case managers
G.	Socialization activities	Number attending socialization activities ÷ by number needing them	Case managers
H.	Residential facility criteria	For each residence: are there formal entry/exit criteria? Y or N	CSP staff
I.	Sheltered workshop placements	Number in sheltered workshop setting ÷ number needing sheltered workshop setting	Case managers

V. Supportive Services of Indefinite Duration

	Aspect	Indicator	Source
A.	Supportive work placements	Number of indefinite work placements ÷ number needed	Case managers
B.	Supportive daytreatment placements	Number of indefinite daytreatment placements ÷ number needed	Case managers
C.	Supportive residential placements	Number of indefinite residential placements ÷ number needed	Case managers

VI. Medical and Dental Care

	Aspect	Indicator	Source
A.	Medical care	Number receiving attention for a medical problem ÷ number needing attention	Case managers

Medical and Dental Care (continued)

	Aspect	Indicator	Source
B.	Dental care	Number receiving attention for a dental problem ÷ number needing attention	Case manager
C.	Medication checks	Number receiving regular medication checks ÷ number receiving medication	Client record
D.	Medical exams	Number of clients receiving at least one medical exam in past year ÷ number of clients	Client record
E.	Dental exams	Number of clients receiving at least one dental exam in past year ÷ number of clients	Client record
F.	Physical rehabilitation	Number of clients receiving physical rehabilitation ÷ number needing it	Case managers

VII. Assistance to Families and Community

	Aspect	Indicator	Source
A.	Case manager contact with families	Number of families contacted ÷ Number of clients with families	Case managers
B.	Case manager contact with landlords	Number of landlords contacted ÷ Number of clients with landlords	Case managers
C.	Case manager contact with employers	Number of employers contacted ÷ Number of clients with employers	Case managers
D.	Case manager contact with legal system	Number of clients legal system contacted on behalf of ÷ number of clients involved in legal system	Case managers

VIII. Involvement of Concerned Community Members

	Aspect	Indicator	Source
A.	Client advocacy	Client advocate group in existence? Y or N	CSP staff
B.	Citizen/relative advocacy	Citizen/relative advocacy group in existence? Y or N	CSP staff
C.	Citizen/relative discussion group	Citizen/relative discussion group in existence? Y or N If Y: CMHC-connected? Y or N	CSP staff

IX. Protection of Client Rights

	Aspect	Indicator	Source
A.	Education of clients regarding their rights	Upon intake to CSP, are clients informed of their rights and how to assert them? Y or N	CSP staff
B.	Written summary	Are clients given a written summary of the grievance procedure? Y or N	CSP staff
C.	Formal written procedure for grievance-processing	1) Procedure in existence? 2) Procedure posted?	CSP staff
D.	"Sign-off? mechanism	Do clients acknowledge in writing that they understand their rights? Y or N	CSP staff

X. Case Management

	Aspect	Indicator	Source
A.	Agreements/contracts with CSP - relevant agencies	Number of agreements/contracts ÷ number of CSP - relevant agencies	CSP staff
B.	Identification of CSP-relevant agencies	Has a list of CSP-relevant agencies been prepared? Y or N	CSP staff
C.	Client to case manager ratio	Number of case managers ÷ number of CSP clients	CSP staff
D.	Number of volunteer case managers	Number of volunteer case managers ÷ number needed	CSP staff
E.	Formal training	Formal procedure for training case managers in place? Y or N	CSP staff
F.	Clients without case managers	1-(Number of clients without case managers ÷ total number of CSP clients)	CSP staff
G.	Treatment plans	Number of clients with treatment plans ÷ total number of CSP clients	Client record
H.	Case staffings	Number of clients receiving case staffings last year ÷ total number of CSP clients	Client record

Appendix B

Longitudinal Follow-along Instrument

(Adapted from an instrument developed

by the Iowa Mental Health Authority)

COMMUNITY ADJUSTMENT INDEX

RATING SCALES

A. INDEPENDENT LIVING SKILLS

Level 1

Self-care and self-maintenance in all aspects, including long-range provisions for the future of self and perhaps family (i.e., insurance, credit, etc.)

Level 2

Self-care and self-maintenance on an immediate basis. Able to handle savings and checking accounts, income tax. May use community resources. Partial dependence on external resources for long-range planning.

Level 3

Self-care and self-maintenance; handles own money for immediate situation and knows and practices basics of physical care and safety. Long-range planning not apparent. Avoids common dangers.

Level 4

Assumes responsibility for self-care and some self-maintenance functions, like choosing own clothes and spending money on some simple things. May not always avoid common dangers.

Level 5

Performs some self-care functions but may sometimes need reminding. May need supervision for clothing choices, caring for belongings, keeping to a schedule, and avoiding dangers.

Level 6

Needs help in most areas of self-care; i.e., toilet needs cleanliness, grooming, eating. Does not recognize or avoid common dangers. Does not keep to own schedule or care for belongings.

Level 0

Information insufficient for rating.

B. INTERPERSONAL RELATIONS

Level 1 — Interaction with others appropriate. Demonstrates concern for others by community or other constructive/ helping activity.

Level 2 — Interaction with others generally appropriate. Lives independently alone, or with family or group of own choosing. Assumes partial responsibility for living group, but does not demonstrate interest or concern beyond that.

Level 3 — Lives independently. Interactions with some others appropriate but with some others may be mildly inappropriate but is not significantly disruptive.

Level 4 — Social interactions with some others usually appropriate and tolerated; with others often inappropriate and disruptive but usually tolerated.

Level 5 — Social interactions with some others may be appropriate; he/she is tolerated, sometimes with difficulty. However, may participate with supervision in structured activities with others. Social interactions with some others often inappropriate and not tolerated.

Level 6 — Does not interact appropriately with either familiar or unfamiliar others. Others, even those most familiar with him/her, do not tolerate his/her behavior.

Level 0 — Information insufficient for rating.

C. COPING WITH STRESS

Level 1 ☐ Remains stable through most of life crises; may become mildly upset, but not dysfunctional, with major crisis or accumulation of crises.

Level 2 ☐ Symptom recurrence under major change or some major life stress.

Level 3 ☐ Symptoms are highly likely to recur under mild to moderate stress. Mild support necessary to control temporary disruptive or regressed behavior following major situational changes or light stress.

Level 4 ☐ With support is able to remain relatively stable under changes in immediate situation; temporary intervention required to control disruptive or regressed behavior following stress.

Level 5 ☐ Remains relatively stable when environment, including schedule, has only minor changes. Major change and other stress may lead to outbursts or other disruptive behavior that requires continued intervention.

Level 6 ☐ May respond to change or other stress with physical attack or even more regressed behavior. Maintaining behavior depends on stability of environment and consistency of routine. Maintaining behavior depends on immediate gratification of his/her needs.

Level 0 ☐ Information insufficient for rating.

D. GENERAL ADJUSTMENT

Level 1 ☐ Functioning well in all areas. No evidence of need for support system.

Level 2 ☐ Functioning well in all areas with minimal indication of stress. Individual needs suggest advisability of occasional support.

Level 3 ☐ Independent functioning socially and vocationally. Occasional evidence of stress necessitates easy availability of supportive or therapeutic services.

Level 4 ☐ At least semi-independent in most areas. Supervision, sheltered environment, or outpatient services necessary for functioning on this level.

Level 5 ☐ Minimal functioning in most areas. Some kind of structured living situation necessary.

Level 6 ☐ Dysfunctional in most or all areas. Almost totally dependent on others for support, protection, self-care.

Level 0 ☐ Information insufficient for rating.

E. Service Utilization Questionnaire

Instructions: Please indicate which of the services below this client has received during the past month. Fill in each box with one of the following codes:

NI - no information

NN - service not needed

NA - service needed, but not available

NR - service needed, but refused

R - service received

☐ A. assistance in applying for benefits from other service agencies

☐ B. other assistance in dealing with other service agencies or legal agencies.

☐ C. training in living skills (for example; cooking, doing laundry, shopping)

☐ D. training in social skills (for example; recreation with others, meeting people, conversational skills, making friends)

☐ E. training in work skills (how to find a job, interview for it, and how to keep it)

☐ F. presence in a sheltered work setting (did your agency assist in arranging this placement? Check one:

yes ☐ no ☐ don't know ☐)

☐ G. presence in a residential living (non-hospital) setting

(facility 1 - hours per week supervised _____

facility 2 - hours per week supervised _____)

☐ H. presence in a competitive employment setting

(did your agency assist in arranging this placement? Check one:

yes ☐ no ☐ don't know ☐)

☐ I. psychiatric inpatient care (including inpatient emergency care)

___ J. state psychiatric hospital care

___ K. outpatient emergency care

___ L. medical or dental care (of a non-psychiatric nature)

___ M. assistance to the client's family, neighbors, employer, or friends

___ N. assistance to client in processing a grievance against your agency

___ O. outpatient (non-emergency) care

Appendix C

SUMMARY OF SERVICES

COMPARING CSP AND ALL CENTER PATIENTS

7/1/79 to 3/31/80

Appendix

SUMMARY OF SERVICES
COMPARING CSP AND ALL CENTER PATIENTS

7/1/79 to 3/31/80

CSP Patients - 7/1/79 to 3/31/80									
Service	# Pts.[1]	%[2]	# Contacts	%	# Hrs.	%	Cost per Unit[3]	Total Cost	%
ıpatient	120	35%	1800	48%	715	45%	$66.77/hr	$ 47,740.55	45%
artial Hosp.	99	49%	3965	67%	14,391	67%	6.95/hr.	100,017.45	67%
mergency	124	18%	342	19%	237	18%	36.27/hr.	8,595.99	18%
utpatient	242	8%	6611	26%	8,928	31%	28.80/hr.	257,126.40	31%
roup Hm.Days	35	57%			4,472days	76%	29.84/day	133,444.48	76%
TOTAL	256	8%	12,718	34%	24,271 hr.	45%		$546,924.87	42%

All Center Patients - 7/1/79 to 3/31/80								
Inpatient	344	---	3770	---	1,582	---	$66.77/hr.	$105,630.14
Partial Hosp.	204	---	5893	---	21,525	---	6.95/hr.	149,598.75
Emergency	704	---	1807	---	1,288	---	36.27/hr.	46,715.76
Outpatient	2,951	---	25,653	---	29,150	---	28.80/hr.	839,520.00
Gr. Hm. Days	61	---	---	---	5,860days	---	29.84/day	174,862.40
TOTAL	3,085		37,123		53,545 hrs.			$1,316,327.05

[1] Unduplicated Count
[2] Percent of All Center Patients, Contacts, Hours, or Cost
[3] Costs as of December 31, 1979.